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**RELIGION-BASED ARGUMENTS IN THE PUBLIC
ARENA: A CATHOLIC PERSPECTIVE ON
EUTHANASIA, *COMPASSION IN DYING* v. *STATE OF
WASHINGTON* AND *QUILL* v. *VACCO*.**

*Patricia L. Rizzo**

INTRODUCTION

In the United States today, using religion-based arguments to shape mainstream public morals and legal opinions can be a startling notion. Yet, perhaps the idea is no more startling than the now common practice of bringing personal morals into the realm of public debate. It is even possible that introducing religious opinions into the purview of legislators and judges, may induce both courts and lawmakers to employ religion-based morality to aid in the nearly impossible task of defining public morals.

**THE RELIGIOUS AND MEDICAL
ROAD TO EUTHANASIA**

In the last two decades, public moral debate has been focused heavily on the issue of a woman's right to privacy, in particular a woman's personal choice to seek an abortion. With this right now clearly established and defined under law, a new area of evolving moral questioning is whether, and when, a person may take his or her own life and have others assist in that process. As in the abortion debate, numerous religious entities have expressed opinions on this subject, based upon principles of faith that either support or attack the concept of a right to end one's life. The Roman Catholic Church is one such entity expressing its views concerning euthanasia based on a highly developed theology.

In contrast to its much publicized stance against abortion, the Catholic Church's position regarding euthanasia is more than "simple opposition." Rather, the Church has a sophisticated moral argument which, while

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staunchly opposed to the deliberate ending of life, nonetheless recognizes the realities of pain associated with a terminal illness, the inability of medicine to always heal, and the inevitability of death. Support for this proposition which is rooted in centuries-old Catholic moral theology, carries merit for anyone who supports life and does not require adherence to all Catholic thought. Utilization of Catholic-based theory does, however, require tolerance by those who traditionally have been opposed to Catholic teachings. Only by taking the time to give the theory genuine consideration, rather than immediately rejecting it based upon its Catholic identity, can its intellectual merits be appreciated.

Although articulated most prominently by the Roman Catholic Church, the fundamental belief that all life is sacred is shared by believers and non-believers worldwide. As the Sacred Congregation for the Doctrine of the Faith wrote in the *Vatican Declaration on Euthanasia*, "Most people regard life as something sacred and hold that no one may dispose of it at will, but believers see in life something greater, namely a gift of God's love, which they are called upon to preserve and make fruitful."¹ The Church has consistently promoted this ancient teaching. For example in *Evangelium Vitae*,² a recent encyclical letter, Pope John Paul II reiterated the Church's opposition to all practices and beliefs that denounce the sacredness of human life, including euthanasia.

Euthanasia, from the Greek for "easy death," or "good death,"³ has come to mean, among other things, the deliberate ending of a human life when a person is suffering from intense, incurable pain, and/or is at the end stage of a terminal illness. For some, the spectacle of such suffering demands that the human spirit be honored by offering a way to end the pain, which may be achieved by ending the life. For others, who believe not only in the sanctity of life but in God as the creator of that sanctity, it is never appropriate to stand in God's stead and direct the ending of a life. Supporters of both positions have attempted to secure judicial and legislative approval of their views.

¹ SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH, VATICAN DECLARATION ON EUTHANASIA (1980) reprinted in KEVIN D. O'ROURKE & PHILIP BOYLE, MEDICAL ETHICS - SOURCES OF CATHOLIC TEACHINGS (1989).

² Pope John Paul II, THE GOSPEL OF LIFE (EVANGELIUM VITAE): (1995).

³ ROBERT N. WENNBERG, TERMINAL CHOICES 3 (1989).

In response to the public debate on euthanasia, the Church has drafted several documents that explain its moral theology.⁴ Although originally intended for a primarily Catholic audience, these treatises and articles can have value in the ongoing public conversation about the right to die. The Church's view does not interpret the sanctity of life as demanding a tenacious hold to human life once the irreversible process of dying has begun. Instead, the Roman Catholic Church teaches that futile treatments need not be endured and medicines that ease pain, even those that may unintentionally hasten death, may be administered. Such practices are not considered euthanasia but simply acknowledgments of life's natural end.

Proponents of euthanasia, which is also referred to as "physician-assisted suicide," have at times attempted to link Church-sanctioned natural termination of life with their own agendas by claiming that the decision to refuse or halt treatment may speed up death as readily as does administration of a lethal dose of prescription drugs. This argument, however, has little merit because the Church's definition of euthanasia is to "dictate the ending of a life," and as opponents of euthanasia have noted, "a bright line exists between allowing nature to take its course by refusing medical treatment and taking active measures to terminate life. The former decision may or may not involve an intent to end life, while the latter always will."⁵

The prominence of the euthanasia discussion today is a direct result of the advanced state of medical science and its capacity to keep patients alive. Since the 1970s, it has been common medical practice in the United States to provide patients with everything medical technology has to offer.⁶ Consequently, decisions regarding the appropriateness of a particular treatment have, in the past, often been made by the patient's

⁴ See SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH, *supra* note 1, at 109; Letter from Pope John Paul II, *supra* note 2; U.S. Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, reprinted in 24 ORIGINS 456 (1994).

⁵ James Bopp, Jr., and Richard E. Coleson, The Constitutional Case Against Permitting Physician-Assisted Suicide for Competent Adults with "Terminal Conditions," 11 ISSUES IN LAW & MED. 253, (1995).

⁶ TIMOTHY E. QUILL, M.D., DEATH AND DIGNITY: MAKING CHOICES AND TAKING CHARGE 29 (1993).

physician rather than the patient or their family.⁷ In response to this situation as well as a combination of financial and ethical constraints, the concept of "medical futility" began to grow in significance. This theory recognizes that when treatment is medically futile, the ultimate decision regarding treatment should be made by the patient⁸ who can choose either to continue the ineffective treatment, or to forego treatment and endure imminent and naturally occurring death.

As medicine has been able to offer more and more treatments to the dying, it has become evident that technology in many cases has not been extending life, but merely lengthening the process of dying. To address the concern created by medical futility, some health care providers introduced the concept of pain management and basic needs care, as opposed to more aggressive treatment. Also known as "palliative care," "comfort care," or "hospice care," this form of patient care acknowledges that patient recovery is not possible, and concentrates instead on providing pain relief as well as social, spiritual, and psychological well-being.⁹

The use of hospices and hospice-type care has been challenged, however, by critics who believe palliative care is insufficient to demonstrate respect for the dying; instead, these critics demand the right to end the life of the sufferer. More recently, this view has been expanded to include not only access to euthanasia, but assistance of the medical community in performing the final act.

Two recent federal appeals court decisions addressed this demand for medical assistance in dying. In *Compassion In Dying v. The State of Washington*, the United States Court of Appeals for the Ninth Circuit, using reasoning derived from abortion right cases, found a constitutional right to die by virtue of the Due Process Clause of the Fourteenth Amendment.¹⁰ In *Quill v. Vacco*, a factually similar case, the United States Court of Appeals for the Second Circuit overturned a district court

⁷ *Id.*

⁸ Renee C. Fox, *The Entry of U.S. Bioethics into the 1990's*, in A MATTER OF PRINCIPLES 35-36 (1994).

⁹ *QUILL*, *supra* note 6, at 23.

¹⁰ *Compassion In Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc), *cert. granted*, 116 S.Ct. 37 (1996).

decision denying the right to die,¹¹ and instead found a constitutional right to die in the Equal Protection Clause.¹² On October 1, 1996, the Supreme Court of the United States granted petitions for writs of certiorari in both these cases, and after briefing arguments in tandem, the cases were heard in January 1997.

DEFINING EUTHANASIA

Euthanasia is a word with many definitions. For example, the American Medical Association (AMA) defines euthanasia as "administration of a lethal agent in order to relieve a patient's intolerable and untreatable suffering."¹³ According to the Catholic Church's *Vatican Declaration on Euthanasia*, euthanasia is "an action or omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."¹⁴ The Church's reference to euthanasia is found, "in the intention of the will and in the methods used."¹⁵ Consequently, for the Church, euthanasia is not defined by the mere administration of comfort care, the cessation or refusal of extraordinary medical treatment, or even the administration of pain medication which may in fact shorten life. Instead, the Church's definition requires an intent to end the life.¹⁶

In the legal world, euthanasia has been defined as "the act or practice of painlessly putting to death persons suffering from incurable and distressing disease, as an act of mercy."¹⁷ Under this definition, it is not necessary that the patient be dying before "mercy death" can be utilized. To compound the confusion, euthanasia is often further divided into sub-types. For example, six categories of euthanasia have been identified:

¹¹ See *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994).

¹² *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), cert. granted, 117 S.Ct. 36 (1996).

¹³ T. Howard Stone and William J. Winslade, *Physician-Assisted Suicide and Euthanasia in the United States*, 16 J. OF LEG. MED. 481, 483 (1995).

¹⁴ SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH, *supra* note 1, at 110.

¹⁵ *Id.*

¹⁶ PONTIFICAL COUNCIL COR UNUM - QUESTIONS OF ETHICS REGARDING THE FATALLY ILL AND THE DYING, (1981) reprinted in KEVIN D. O'ROURKE & PHILIP BOYLE, *MEDICAL ETHICS - SOURCES OF CATHOLIC TEACHINGS* 114 (1989).

¹⁷ BLACK'S LAW DICTIONARY 554 (6th ed. 1990).

- (1) passive euthanasia, or failure to treat the patient with any extraordinary measures;
- (2) semi-passive euthanasia, involving the cessation of treatment already begun;
- (3) semi-active euthanasia, the actual disconnection of a patient from a respirator;
- (4) accidental or "double effect" euthanasia, resulting from administration of pain medication with a second, unintended effect of causing death;
- (5) suicide or physician-assisted suicide conducted by the patient herself, or with a prescription provided by a physician who allows the patient to consume a lethal dose of drugs; and
- (6) active euthanasia involving death by lethal drugs administered by a physician.¹⁸

In addition, further distinctions can be made between "voluntary" and "involuntary" euthanasia. Voluntary euthanasia has been defined as "allowing the physician to take final action that brings on a patient's death."¹⁹ The decision to die in this instance emanates from the patient and no one else.²⁰ In contrast, most consider involuntary euthanasia to be murder,²¹ because the decision to end the terminally ill patient's life is made against the wishes or without the knowledge of the patient.²²

For the Church, inclusion of "refusal" or "cessation" of treatment in the definition of euthanasia is problematic and forces the issue to be focused upon intent. According to Catholic moral teaching, unless the actual intent to end a person's life is present, euthanasia has not occurred. Others disagree and find that where death is produced, whether intended or not, euthanasia has occurred.²³ The Church, and those who follow its line of reasoning, have countered this argument with the theory of "double

¹⁸ See *It's Over, Debbie*, 259 JAMA 272 (1988) (anonymous letter describing physician-author's administration of lethal dose of morphine to patient in great distress and dying of incurable ovarian cancer who asked that death be advanced).

¹⁹ Jerald G. Bachman, et al, *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 NEW ENG J. MED. 305 (1996).

²⁰ QUILL, *supra* note 6, at 142.

²¹ WENNBERG, *supra* note 3, at 9.

²² QUILL, *supra* note 6, at 142.

²³ *Id.* at 144.

effect," which proposes that there is a moral distinction between intending evil and having evil result, or merely permitting evil to occur as a by-product of the good effect.²⁴ By employing this principle, the Church has concluded that it is licit to perform an action which has good and bad effects provided that the action itself is not morally bad; that the evil effect is sincerely not desired, but merely tolerated; that the evil is not the means of obtaining the good; and that the good effect is sufficiently important to balance or outweigh the harmful effect.²⁵

Proponents of euthanasia have also categorized various modes of ending a human life, finding some forms to be euthanasia and others not. This reluctance on the part of euthanasia defenders to outright label activities as "euthanasia" may stem from the fact that many people, although fundamentally in favor of the right to choose the time of one's own death, nonetheless regard the term euthanasia as implying an involuntary process. For example, "physician-assisted suicide" is a term that means the patient performs the actual final act, but is assisted by a physician. Typically this involves the patient's consumption of lethal drugs prescribed by a physician.²⁶ The right to this particular mode of suicide was recently upheld both in *Compassion In Dying* and *Quill*.²⁷ Other terms used to describe the intentional ending of a life include "physician-aid-in-dying" and "physician-assisted death," which not only include suicide, but also include active participation by the physician who may administer a lethal dose to the patient. In this scenario, administration of a lethal dose of medication would not necessarily be limited to the terminally ill.²⁸

Finally, some additional definitions that are imperative to consider in this discussion, focus on the meaning of the term "death," and what constitutes extraordinary and ordinary treatments. The Church, for its part, has defined "death" as occurring when a person "has irreversibly lost

²⁴ William May, Double Effect, in _____ Encyclopedia of Bioethics _____, _____ (W. Preich ed. 1978).

²⁵ GERALD KELLY, MEDICO-MORAL PROBLEMS 129 (1958).

²⁶ QUILL, *supra* note 6, at 159.

²⁷ See *Compassion In Dying v. Washington*, 79 F.3d 790, 838 (9th Cir. 1996); *Quill v. Vacco*, 80 F.3d 716, 727 (2d Cir. 1996).

²⁸ Franklin G. Miller et al, *Regulating Physician-Assisted Death*, 331 NEW ENG. J. MED. 120 (1994).

all capacity to integrate and coordinate the physical and mental functions of the body." Thus, death occurs when: the spontaneous cardiac and respiratory functions have definitively ceased; or an irreversible cessation of every brain function is verified.²⁹ Where a patient is in a permanent coma, there is no obligation to provide treatment other than comfort care. However, if it can be established clinically that there exists a possibility of recovery, then there is an obligation to provide medical treatment.³⁰ In contrast to this definition, a 1968 Harvard Medical School commission defined death as the lack of brain waves, as reflected by an electroencephalogram (EEG).³¹ While the Church's definition of death seems to require an absolute guarantee of the impossibility of recovery, the Harvard definition gives greater confidence to a single, albeit extremely significant, indicator.

In attempting to define what constitutes "treatment," United States Catholic bishops have recently reasoned that:

while every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged ... not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.³²

Clearly, not every means available need be considered in determining which medical procedures to pursue. Rather, an analysis is called for to identify the particular treatments that have a reasonable chance of improving the patient's condition, and those which are either useless or too burdensome to endure. The inclusion of "expense" as an element of consideration is a recent addition to the equation, and reflects the Church's awareness of how this factor all too often figures into decisions regarding medical treatment.

²⁹ THE CHURCHES SPEAK ON: EUTHANASIA 20 (J. Gordon Melton ed., 1985).

³⁰ PONTIFICAL ACADEMY OF SCIENCES REPORT ON PROLONGING LIFE AND DETERMINING DEATH (1985), reprinted in KEVIN D. O'ROURKE & PHILIP BOYLE, MEDICAL ETHICS - SOURCES OF CATHOLIC TEACHINGS 67 (1985).

³¹ SUICIDE AND EUTHANASIA: THE RIGHTS OF PERSONHOOD 7 (Samuel E. Wallace and Albin Eser eds., 1981).

³² U.S. Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, reprinted in 24 ORIGINS 456 (1994).

As an alternative to the benefits/burdens analysis, at least one commentator, Protestant ethicist Paul Ramsey, has advocated use of a "medical indications" policy in which only those treatments that are "medically indicated" for the patient are considered to be "ordinary." All other treatments are considered "extraordinary" and can in good conscience be refused.³³ Employing logic compatible with the Church's teachings, Ramsey has argued that once it is established that a person is dying and there is no hope of recovery, no treatment is medically indicated.³⁴

Although the Church usually requires that comfort care be extended even when recovery is medically impossible, arguments based on Catholic moral teaching have been expanded in certain situations so that even hydration and nutrition may be deemed "extraordinary" and can morally be ended.³⁵ This movement in what has essentially been a firm position, is due no doubt in part to the controversial cases of Karen Quinlan and Nancy Cruzan who each had their dying process agonizingly prolonged, in part through the simple measure of providing nutrition and liquids.³⁵

Although this is merely a small sample of the variety of definitions of euthanasia and related terms in use throughout the medical, legal and ethical communities, it is obvious that uniformity of definitions is lacking. Universally agreed upon terminology would greatly facilitate not only debate and legislation, but ultimately, patient care. For example, those who support the right to end one's life have largely ignored the distinction that exists between using euthanasia in order to kill; physician-assisted suicide; and allowing death to occur naturally through cessation of medically futile treatments.

Ironically, these same supporters also cling to a fabricated distinction between physician-assisted suicide and euthanasia, although the result is identical in bringing about the patient's death through intentional means, either by the patient's own hand or that of her physician. Whenever the life of the patient is cut short through administration of drugs designed

³³ PAUL RAMSEY, *ETHICS AT THE EDGE OF LIFE* 156-157, 188 (1978).

³⁴ *Id.* at 268.

³⁵ CARDINAL JOSEPH BERNADIN, *AN ADDRESS TO THE CENTER FOR CLINICAL MEDICAL ETHICS* (1988) reprinted in *THE CHURCHES SPEAK ON: EUTHANASIA* 20, 29 (J. Gordon Melton, ed. 1985).

³⁶ See *In re Quinlan*, 348 A.2d 801 (N.J. 1975), *cert. denied*, 97 S.Ct. 319 (1976); *Cruzan v. Director, MO. Dep't of Health*, 497 U.S. 261, *cert. granted*, 110 S.Ct. 2841 (1990).

exclusively to end the life, and is not allowed to come to its natural termination, it is "euthanasia." Consequently, any concept of "passive" euthanasia is false, as there can be nothing passive about choosing to terminate a life. Instead, the term "euthanasia" should be applied to all procedures that are intended to cause death, and should not be extended to those instances in which a natural death is allowed to occur.³⁷

PUBLIC MORALS AND THE LAW

Since the early 1980s, there has been an ongoing public conversation about euthanasia and the individual's right to make decisions regarding medical treatment, including the right to end one's life. In a now famous article entitled, "It's Over, Debbie," published in January 1988 in the *Journal of the American Medical Association* (JAMA), an anonymous resident confessed to his alleged administration of lethal drugs to a young, terminally ill cancer patient in order to end her uncontrollable pain. The piece drew considerable comment and criticism against the editorial board of JAMA for printing the controversial and potentially unverified article, thereby tacitly implying its approval of the physician's actions. JAMA countered these accusations by stating that the purpose of the article was to stimulate debate about euthanasia.³⁸

In 1990, Congress responded to public concern about the right to die by passing "The Patient Self-Determination Act,"³⁹ under which all health-care facilities receiving Medicaid or Medicare subsidies are required to ask each patient on admission whether an advance directive has been completed. Each facility must now advise patients of its own policies regarding the honoring of advance directives, as well of the patient's right to refuse treatment.⁴⁰

³⁷ Marcel Gervais, *Report of Testimony Before Canadian Senate's Committee on Assisted Suicide and Euthanasia - Oct. 26, 1994*, 24 ORIGINS 394 (1994). Paul Ramsey concurred with this reasoning in establishing a dichotomy between "dying well," which involves choosing death, and what he termed, "dying well enough," which is never a choosing of death, but rather an acceptance of it at its natural time.

³⁸ *It's Over Debbie*, *supra* note 18, at 2142.

³⁹ Patient Self-Determination Act of 1990, Pub. L. No. 101-508, 104 Stat. 1115, 205 (codified as amended in scattered paragraphs of 42 U.S.C. § 1395).

⁴⁰ QUILL, *supra* note 6, at 189.

Physicians and other health-care professionals have also expressed support for the participation of caregivers in euthanasia. For example, an article by a group of physicians published in the *New England Journal of Medicine*, stated that physician assistance in committing euthanasia, "serves the moral goals of relief of suffering and self-determination on the part of patients."⁴¹ The physicians concluded that they "... regard physician-assisted death as a non-standard medical practice reserved for extraordinary circumstances, when it is requested voluntarily by a patient whose suffering has become intolerable and who has no other satisfactory options."⁴² While this group of physicians held that comfort care should be the standard treatment for dying patients, they nonetheless saw a place for euthanasia and would not limit it to the terminally ill, but would include those with "incurable debilitating illnesses."⁴³

In Michigan and Oregon, two states with active advocates of euthanasia, recent polls revealed that the medical communities in each state are to some extent favorably disposed toward euthanasia, even when it includes physician participation. According to the 1994-1995 Michigan poll, the majority of physicians surveyed favored legalization of euthanasia, or at least maintaining the status quo of not openly permitting euthanasia but also not attaching criminal liability to physicians who assist in patient suicide.⁴⁴

The Oregon poll was most likely prompted by the November 1994 passage of the Oregon Death With Dignity Act,⁴⁵ which allowed physicians to legally assist in patient suicides. In August 1995, however, the United States District Court for the District of Oregon found the Act unconstitutional, because it denied terminally ill patients the same protection that exists for the rest of the population.⁴⁶ The District Court decision was subsequently appealed to the United States Court of Appeals

⁴¹ Miller, *supra* note 28, at 119.

⁴² *Id.*

⁴³ *Id.* at 120.

⁴⁴ Bachman, *supra* note 19, at 303.

⁴⁵ OR. LAWS 1995, ch. 3, § 1.01.

⁴⁶ Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995).

for the Ninth Circuit, which issued an injunction on the Act that remains in effect pending its ruling.⁴⁷

The Oregon poll, completed in 1995, indicated that 60 percent of physicians believe physician-assisted suicide should be legal in some cases. At least 48 percent of the physicians admitted they would be willing to prescribe a lethal dose, while 31 percent stated they would be unwilling to do so on moral grounds.⁴⁸ Another interesting statistic which emerged from this study was that half of the physicians polled were uncertain what medication to prescribe to a patient that might be taken as a lethal dose.⁴⁹

In addition to physicians who support euthanasia, a large segment of the general public has also become vocal on the issue. Some supporters have echoed arguments that were made successfully in the abortion rights arena, claiming that if a woman's right to control her own body includes the right to have an abortion, "when that same woman at a later stage of her life becomes terminally ill, her right to control her own body must include her right to make decisions about the voluntary termination of her own life during the end stages of her terminal illness."⁵⁰ If these proponents of the "right to die" are correct, however, the right to end one's own life and to have a physician's assistance cannot reasonably be limited to the terminally ill. It is a right that would belong to anyone, at any time.⁵¹

The political and social environment surrounding euthanasia has clearly been one of debate, although a growing sector of the population is voicing its support for laws that de-criminalize suicide assistance or create a positive right to seek and offer such aid. Into this debate have stepped two federal appellate courts faced with the responsibility of crafting new public morals that support the right to die.

⁴⁷ Lee v. Oregon, Nos. 95-35854, 95-35948, 95-35949 (9th Cir.), argued July 9, 1996 (decision pending).

⁴⁸ Melinda A. Lee, et al, *Legalizing Assisted Suicide - Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 313 (1996).

⁴⁹ *Id.*

⁵⁰ Robert A. Sedler, *Are Absolute Bans on Assisted Suicide Constitutional? I Say No*, 72 U. DET. MERCY L. REV. 729 (1995).

⁵¹ Yale Kamisar, *Against Assisted Suicide - Even A Very Limited Form*, 72 U. DET. MERCY L. REV. 766 (1995).

Compassion in Dying v. State of Washington
and *Quill v. Vacco*

In *Compassion In Dying v. The State of Washington*,⁵² the Ninth Circuit, in an *en banc* decision, reversed its original panel and upheld the opinion of the United States District Court for the Western District of Washington that had found a portion of Washington Statute 9A.36.060, that criminalizes assistance given a person who attempts to commit suicide, to be unconstitutional.⁵³ In *Compassion In Dying*, a group of terminally ill patients and their physicians, as well as "Compassion In Dying," an entity that seeks the legal right to assist its members to commit suicide, brought suit to overturn portions of the Washington law banning assisted suicide.

In reaching its decision, the Ninth Circuit first defined the term euthanasia as "the act or practice of painlessly putting to death persons suffering from incurable and distressing disease, as an act of mercy, but not at the person's request."⁵⁴ Before beginning its analysis of the case, the appeals court emphasized that it would focus upon whether a constitutional right to die can be said to exist, rather than the narrower issue of whether there exists a right to die with the assistance of a physician.⁵⁵ Nonetheless, because the court was compelled to reach its decision within the confines of the particular facts of the case, it was also forced to address specific physician-assistance issues.

Ultimately, not only did the Ninth Circuit find a constitutional right to die, but it also found a constitutional right to die that consisted of having a physician prescribe medication for the patient to self-administer.⁵⁶ For the court, there was no problem accepting physician-assisted suicide, which it interpreted as a logical extension of Washington law that already permitted competent patients to refuse or to terminate treatment.⁵⁷ The court refused however, to find a right to other forms of euthanasia such as physician-aid-in dying, where the physician not only prescribes the

⁵² *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996).

⁵³ See *Compassion In Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994).

⁵⁴ *Compassion In Dying*, 79 F. 3d at 832 n. 120.

⁵⁵ *Id.* at 801.

⁵⁶ *Id.* at 793.

⁵⁷ *Id.* at 817.

medication but also administers the fatal dose.⁵⁸ Similarly, the court also found that disconnecting a respirator, ceasing nutrition or hydration, or administering pain medication that has the "double effect" of easing pain and hastening death, are all means of intentionally causing death.⁵⁹ As the court held:

We see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient's life. Similarly, we see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life.⁶⁰

For the *Compassion In Dying* court to reach its conclusion, it was initially necessary for the court to construct a definition of euthanasia that encompassed involuntary euthanasia only, which is illegal everywhere in the United States.⁶¹ The court then distanced itself from condoning such activity, and sought instead to establish an artificial distinction between a death resulting from a physician who merely prescribes a lethal medication to a patient, and a physician who actually administers the medication to a patient. Finally, the court negated a genuine distinction between the intent to kill and the acceptance of death, by refusing to allow for the "double-effect" principle in which medication needed to control pain may unintentionally cause a quicker death.⁶²

The court's reluctance to acknowledge "intent" as a principal element in identifying euthanasia is remarkable, as intent is a prominent concept in both United States civil and criminal jurisprudence. For example in the civil realm, intent is examined to determine if a tort constitutes mere negligence, gross negligence, or wanton misconduct. Fines, penalties, and jury awards differ significantly depending on the mode of malfeasance found to exist. In the criminal setting, intent is of crucial importance and

⁵⁸ *Id.*

⁵⁹ *Compassion in Dying v. Washington*, 79 F. 3d 790, 822 (9th Cir. 1996).

⁶⁰ *Id.* at 824.

⁶¹ *Id.* at 832 n. 120.

⁶² *Id.* at 823.

is used to differentiate among the degrees of murder and manslaughter, as well as serving as a dividing line between felonies and misdemeanors. Intent can also be the primary determinative in assessing a crime as a capital offense. In short, intent is a concept utilized throughout the law, and it is one the *Compassion In Dying* court chose to ignore.

Instead, the majority opinion in *Compassion In Dying* employed false logic both by ignoring the element of intent and by declining to call physician-assisted suicide "euthanasia" on the meaningless distinction that the physician does not herself administer the deadly medications. This incongruity was noted by Judge Beezer who wrote in his dissent,⁶³ "The proper place to draw the line is between withdrawing life-sustaining treatment ... and physician-assisted suicide and euthanasia.... The former is constitutionally protected the latter are not."⁶⁴

Despite the logic presented in the dissenting opinions in *Compassion in Dying*, the majority chose to find a liberty interest in the right to die, emanating from the Due Process clause of the Fourteenth Amendment and based upon essentially the same reasoning employed by the United States Supreme Court in finding a woman's right to choose to have an abortion. While acknowledging the right of the state to preserve life, the court found that once the right to die has been identified as a liberty interest, the state's interest is substantially diminished when a competent adult no longer wishes to continue living.⁶⁵

The reasoning employed by the majority in *Compassion in Dying* is contrary to traditional Catholic moral thought in that it bypasses the concept of the sanctity of life in favor of establishing a human-made right to end life. The court also articulated the belief that greater value is attached to some lives over others. In a powerfully-reasoned brief, the United States Catholic Conference argued that the plaintiffs' case was essentially proposing that some individuals are better off dead than alive.⁶⁶ This conference argued that such a conclusion could only be made by those employing quality-of-life paternalism -- the belief that the value of

⁶³ *Id.* at 840.

⁶⁴ *Compassion in Dying v. Washington*, 79 F. 3d 790, 840 (9th Cir. 1996).

⁶⁵ *Id.* at 820.

⁶⁶ Amicus Brief, United States Catholic Conference, in Support of Appellants, State of Washington, filed July 11, 1994, at 29.

a life is determined by those who surround it and communicate to the ill or dying person that a life robbed of abilities is one devoid of meaning and should be ended.

In *Quill v. Vacco*,⁶⁷ the United States Court of Appeals for the Second Circuit reversed a lower court opinion and reached the same result as reached in *Compassion In Dying*, but for a different and potentially more significant reason. In *Quill*, a group of physicians joined with their terminally ill patients to challenge New York statutes which criminalized providing aid to a person committing suicide. The plaintiffs appealed a summary judgment order entered on behalf of defendants by the United States District Court for the Southern District of New York, upholding the constitutionality of the statutes.⁶⁸ The plaintiffs argued that New York Penal Law Sections 120.30 and 125.15 violated both their liberty interests under the Due Process clause as well as their Equal Protection rights. The Second Circuit Court of Appeals, however, declined to recognize the right to die as a liberty interest and, instead, found a right of the competent, terminally ill patient to choose to end his or her life in the Equal Protection clause.

Following the reasoning of *Compassion In Dying*, the *Quill* court explained that it would not decide the legality of euthanasia, which would not be tolerated in the United States as it is in countries such as the Netherlands. Rather, the court maintained that it would merely establish whether the terminally ill are entitled to the assistance of a physician to end their lives.⁶⁹ As a result, the Second Circuit, like the Ninth Circuit, refused to address the issue of "euthanasia," and by doing so avoided confronting the core of the debate, namely the right to kill. Consequently, for the Second Circuit, actual murder remains the only act that can be called euthanasia.⁷⁰

By likening the administration of pain medication that inadvertently shortens life with the prescription of drugs for the intentional and exclusive purpose of ending life, the *Quill* majority revealed its refusal to acknowledge intent behind the action as a means of determining what is

⁶⁷ *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), cert. granted, 117 S.Ct 36 (1996).

⁶⁸ See *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994).

⁶⁹ *Quill*, 80 F.3d at 730-731.

⁷⁰ *Id.*

and is not truly euthanasia. Similarly, by failing to distinguish between suicide and the refusal or termination of certain treatments, the court also tried to claim as supporters of euthanasia, proponents who believe in the sanctity of life and yet acknowledge dying as a natural process that should not necessarily be impeded by application of useless medical procedures.⁷¹

Based upon the Second Circuit Court's understanding that the Equal Protection clause demands that individuals similarly situated be treated in a similar manner, the majority of the court held the state had no rational basis for a law that treats certain competent and adult terminally ill patients differently. The reasoning behind this conclusion is that in New York a terminally ill patient who requires a respirator or other device or procedure to live can opt to forgo the treatment and, thereby, advance the event of her death. In contrast, a patient who is terminally ill but not dependent on any device or treatment is forestalled from initiating any "treatment" that may ultimately cause death.⁷²

Like *Compassion In Dying*, the reasoning of the *Quill* court obliterates examination of the intent involved in these two different situations. In the first instance, a patient chooses to forego medical assistance that is not keeping her alive so much as it is keeping her from death. In the second, the patient chooses to deliberately challenge death by dictating the moment of its arrival. In support of this distinction, it must be noted that in the first example, if the patient is not terminal and if the respirator or other treatment is actually providing a benefit to the patient, the deliberate refusal to accept treatment would be contrary to moral reasoning employed both by the Church, and others who respect the sanctity of life. In that instance, the action of the patient would have to be described as suicide.

Now that two appellate court decisions have individually found the existence of a constitutional right to die, it seems appropriate that the United States Supreme Court review this important public policy issue. Ratification of the legal basis for the *Quill* decision is an even greater concern for those opposed to euthanasia, because it requires greater stretching of the Constitution than does an argument based on invention of a "novel liberty interest." The current Supreme Court has in recent

⁷¹ *Id.*

⁷² *Id.* at 729.

years demonstrated reluctance to develop new fundamental rights,⁷³ and a right based on Equal Protection would stand on firmer ground and make it more likely that a constitutional right to die becomes accepted as law of the land.

Although the right to die is currently limited to the Second and Ninth Circuits, the introduction of this right raises enormous issues for patients and health-care professionals. For example, consider a hospital that does not wish to honor a patient's request for assistance in committing suicide. Alternatively, what if the patient making the request is too physically weak to be transferred to another facility? Should a hospital accept a patient who enters their facility for the exclusive purpose of committing suicide?⁷⁴

Both *Compassion In Dying* and *Quill* are limited in application to the terminally ill. The process of *stare decisis* however, is such that prior decisions form the foundation for new ones, which in turn are enlarged to support new facts. It is only a matter of time before *Compassion In Dying* and *Quill* are cited to support the legality of the actions of euthanizers such as Jack Kevorkian.

What also remains unclear is how to define which individuals are terminally ill. In the Oregon physician survey, half of the respondents did not feel confident in predicting a patient's life expectancy, which under Oregon law requires a maximum prediction of six months until death in order to be considered "terminal."⁷⁵ For jurisdictions governed by *Compassion In Dying*, an additional problem may be expected to surface as individuals who are not terminally ill also seek the right to end their

⁷³ For example, in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), an abortion rights case that considered the constitutionality of restrictions to the right to have an abortion enacted in Pennsylvania, the Court reconsidered the continuing viability of *Roe v. Wade*, 410 U.S. 113 (1973). In complex and struggling opinions, the plurality confirmed the central holdings of *Roe*, but without a strong articulation of the right to have an abortion as "fundamental," 505 U.S. at 844-869. With the exception of Justice Blackmun's concurrence and dissent, 505 U.S. at 922-929, the plurality's substantial focus is on the propriety of following *stare decisis* in reconsidering *Roe*, not a ringing endorsement of the right to abortion as a fundamental right. In contrast, the four dissenters actually termed the right as "non-fundamental," and completely subject to state regulation.

⁷⁴ Amicus Brief, Washington State Hospital Association and Catholic Health Association of the United States, in Support of Appellants, State of Washington, filed July 11, 1994, at 8.

⁷⁵ Lee, *supra* note 48, at 313.

lives based on the argument for liberty and autonomy interests. Consequently, if the right to end life is based on one's autonomy, a patient's medical condition and motivation for seeking suicide become irrelevant.⁷⁶

CATHOLIC MORAL THOUGHT IN PUBLIC DEBATE

In *Evangelium Vitae*, Pope John Paul II offered a response to the tangle of issues surrounding euthanasia that to believers in the sanctity of life may seem simple in its integration and consideration of the problem. To non-believers, it may appear only naively simplistic. John Paul unmasks euthanasia as bringing a "gentle" death, and reveals it as a way to end a life that has been judged useless and without value.⁷⁷ In repeating the Catholic doctrine that a determination must be made regarding the attendant improvement to the patient that may result from a treatment as opposed to the burden the patient will be forced to endure, John Paul affirmed the teaching that futile medical treatments do not have to be initiated or continued in order to respect the sanctity of life.⁷⁸ Such a consideration does not constitute euthanasia; instead, "it rather expresses acceptance of the human condition in the face of death."⁷⁹

Although Pope John Paul II has been a vigorous advocate of the sanctity of life, and has been verbal in his condemnation of euthanasia, he is but the latest in a long line of popes to take such an approach. Pope Pius XII, referencing the form of euthanasia used by the Nazi regime, wrote in *Acta Apostolicae Sedis*:

... [W]e see at times the deformed, the insane and those suffering from hereditary disease deprived of their lives, as though they were a useless burden to society; and this procedure is hailed by some as a manifestation of human progress, and as something that is entirely in accordance with the common good. Yet who that is possessed of sound judgment does not recognize that this not only violates the

⁷⁶ Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 NOTRE DAME L. REV. 519, 527 (1995).

⁷⁷ Pope John Paul II, *supra* note 2, n. 64.

⁷⁸ *Id.* at n. 65.

⁷⁹ *Id.*

natural and divine law written in the heart of every man, but that it outrages the noblest instincts of humanity.⁸⁰

Although originally issued in response to Nazi atrocities, the words of Pius XII bring great insight to the euthanasia doctrine in general. Pius XII repeats that only God has the right to take the life of an innocent and while human suffering should be avoided, the suffering itself may hold special merit for the sufferer in light of the Redemption.⁸¹ To accept the reasoning of Pius XII and John Paul II requires both acceptance of the natural law and the belief that as humans we do not morally possess the right to do all that we desire. In this modern world, there is great resistance against accepting the possibility that there may be a law or a law-giver who stands above human law and will.⁸²

The process of dying is often painful and lacking in dignity, peace or beauty. But it has become part of American culture to pretend these facts do not exist, and to become angry when made to confront them. Dr. Sherwin Nuland, a proponent of the right to die, expressed in his book *How We Die*, that he wrote "to demythologize the process of dying," and to present death "in its biological and clinical reality."⁸³

Another view is that of Dr. Timothy Quill, advocate for physician-aid-in-dying and the litigant in *Quill*, who believes that when a patient is dying, "alleviating suffering becomes more important than prolonging life."⁸⁴ Here, the views of Dr. Quill and Catholic moral thought are in agreement, but they separate when Quill, and others who share his view, fail to advocate for comfort care and instead argue for the right of the dying patient to end his life. This conduct may be considered abandonment of the dying in the truest sense of the word because it encourages the patient's belief that they are no longer wanted or needed in this world, the very opposite of recognizing the dignity of a person's life and death.

⁸⁰ KELLY, *supra* note 25, at 2-3.

⁸¹ *Id.* at 3.

⁸² *Id.* at 5.

⁸³ SHERWIN B. NULAND, *HOW WE DIE: REFLECTIONS ON LIFE'S FINAL CHAPTER* xvii (1994).

⁸⁴ QUILL, *supra* note 6, at 36.

Many supporters of the right to die claim that the dying who seek a speedy death are not depressed, but merely making rational decisions about ending their lives. Others, however, point out that if a person who is not terminally ill seeks to commit suicide, he or she is considered to have a mental or emotional illness and precautions are taken to prevent a suicide. In contrast, when a terminally ill patient wants to end his life, people line up in readiness to assist.⁸⁵ This is due again to a belief in the qualitative value of life. As stated by the *Quill* court, "Surely, the state's interest [in protecting life] lessens as the potential for life diminishes."⁸⁶

Nondisabled persons seeing the life of a disabled patient might assess that were they deprived of their physical abilities they would want to end their own lives, and thus "might come to view the right to die as a social program in the best interests of those who are disabled."⁸⁷ Instead, a request for suicide should be seen as a plea for help -- in the form of pain management and human comfort and society.⁸⁸ It has been established that most terminal patients can be relieved from pain, provided their physicians are committed to the process.⁸⁹ Once the pain is diminished and the patient feels connected to his community, there is generally little discussion about euthanasia.⁹⁰

CONCLUSION

Borrowing from its opponents, the *Vatican Declaration on Euthanasia* of the Sacred Congregation for the Doctrine of Faith identifies the "right to die" as a "right to die peacefully with human and Christian dignity," and not the right to procure the death of self or of others.⁹¹ This dignity

⁸⁵ Chopko, *supra* note 76, at 531; Stanley S. Herr, et al., *No Place To Go: Refusal of Life-Sustaining Treatment by Competent Persons with Physical Disabilities*, 8 ISSUES IN L. & MED. 23 (1992-93).

⁸⁶ *Quill v. Vacco*, 80 F.3d. 716, 729 (2d Cir. 1996), *cert. granted*, 117 S.Ct. 36 (1996).

⁸⁷ Stanley S. Herr et al., *No Place To Go: Refusal of Life-Sustaining Treatment by Competent Persons with Physical Disabilities*, 8 ISSUES IN L. & MED. 23, 32 (1992).

⁸⁸ As seen in both *Compassion In Dying v. Washington* and *Quill v. Vacco*, all patient-plaintiffs stated that their pain was uncontrollable and unbearable.

⁸⁹ Amicus Brief, United States Catholic Conference, *Compassion In Dying*, at 25.

⁹⁰ RAMSEY, *supra* note 33, at 152 (quoting Cicely Saunders, M.D., leader in the hospice movement in Great Britain).

⁹¹ SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH, *supra* note 1, at 321.

persists even in the face of enormous pain that can "turn us outward, enabling our capacity to respond with a compassionate presence to the bodily and psychic afflictions of others."⁹²

In contrast, the "appeal for legalized euthanasia seems thus to reflect a flight from compassion rather than an expression of compassion."⁹³ True compassion, in the care of the dying, requires great strength of character, because the sight of the suffering of others is difficult to endure: As Leon R. Kass, author of *DEATH WITH DIGNITY AND THE SANCTITY OF LIFE* explained, "Above all, we must not allow ourselves to become self deceived: We must never seek to relieve our own frustrations and bitterness over the lingering deaths of others by pretending that we can kill them to sustain their dignity."⁹⁴

Compassion and dignity require that in the face of unbearable suffering, we respond to the call to affirm life to the dying person. This does not mean that we demand the dying to hold onto life at all costs, but merely to recognize there is dignity and sanctity in each moment of life as well as through the moment of death, which must be allowed to arrive at its own natural time. Dignity at death means being given a hand to hold and having care that maintains control over pain, rather than being pushed into a premature and unnatural death.

Because the right to die has now been established as a Constitutionally-protected right by at least two federal appellate courts, its development, use, and operation will occupy the court and legislatures who have once again been called upon to establish national morals. The moral theology of the Catholic Church should be welcomed into this public debate and should be permitted to influence, shape and contribute to formulation of the law alongside other theories and philosophies, both secular and spiritual.

Uniformity in terminology must also be injected into the debate. Intent, a concept so critical in American criminal and civil law definitions, must be acknowledged in the unfolding of this new right to die.

⁹² Courtney S. Campbell, *Principleism and Religion - The Law and The Prophets*, in *A MATTER OF PRINCIPLES* 203 (E. DuBose ed., 1994).

⁹³ *Id.*

⁹⁴ Leon R. Kass, *Death with Dignity and the Sanctity of Life*, in *A TIME TO BE BORN AND A TIME TO DIE* 140 (B. Kogan ed., 1991).

Euthanasia, a term which both the Second and Ninth Circuits refused to acknowledge, must be used to describe what these courts approved — the intentional killing of person at that person's request. Calling this process "physician-assisted suicide" or some other term designed to ease the consciences of the litigants, attorneys, and judges, does not disguise what the courts have in fact approved. The challenge for the United States Supreme Court now, is to undo the damage caused by *Compassion In Dying* and *Quill* and to return the work of the court to its traditional function, by supporting the preservation of life.

In view of the current trend to accept, allow and encourage euthanasia, opponents are struggling to re-focus discussion on the sanctity of life, and to reveal euthanasia not as the merciful, dignified ending it announces itself to be, but as the killing of a person in direct opposition to any respect for life. In this argument, religious views can be of significance, even if they are not identified specifically as "religious." For example, the concept of a consistent ethic of life, expounded by the late Cardinal Bernardin, can be used to challenge proponents of euthanasia and does not require acceptance of Roman Catholic doctrine to speak to its validity.⁹⁵ As world leaders struggle to honor the sanctity of life, the Catholic Church is in the unique position of offering the world its long-held and well-articulated beliefs why euthanasia is wrong, thereby bringing theology into public debate in a meaningful way.

⁹⁵ Campbell, *supra* note 92, at 206.

